

~~OFFICIAL USE ONLY~~

PATIENT NAME:  
SOCIAL SECURITY #:  
BADGE #:  
DATE OF INJURY: 03/07/00  
DATE OF REPORT: 03/07/00  
SITE CODE: 140

S: This machinist developed some excessive watering of his right eye and some irritation of his throat today after working for about 3 hours in Building 9201-5E inspection area. He states there were two through-the-wall air conditioning units in this area that have had their filters removed. These had visible dust inside the units, and dust was settled over the environment in the area, which he states was new and different. He expresses a concern that this could be beryllium since it is a beryllium area. He denies any fever. He has had minimal cough. He was not wearing a respirator.

O: He is conscious, alert, oriented, and in no acute distress. ENT exam is normal except for bilateral ceruminosis. Skin of the face is normal. Eye exam shows pupils are equal, round, and reactive to light. Extraocular movements are full. A small area of injection involves the conjunctivae. Bilateral fluorescein exam with a slit lamp is negative for corneal abrasion or stippling. No foreign body is seen. I have irrigated the eyes with sterile eye wash solution.

A: 1. THROAT IRRITATION.  
2. EXCESSIVE LACRIMATION, ~~BILATERAL EYES.~~ *Reye*  
3. DUST EXPOSURE, AND THE EMPLOYEE IS CONCERNED ABOUT BERYLLIUM EXPOSURE.

P: I called Tom Ford, manager of Industrial Hygiene, and advised him of the situation. I requested that Industrial Hygiene look into this situation and report back to Medical. I have dispensed throat lozenges and Artificial Tears to use p.r.n. A recheck date will be tomorrow, March 8, 2000. He is to return sooner if he has more difficulties. He is placed on a temporary medical restriction of no working in Building 9201-5E or dusty or low-humidity environments.

*[Signature]*  
STAN ROBERTS, PA-C

SR:cmh

Dictated but not edited

D: 03/08/00  
T: 03/08/00

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PATIENT NAME:  
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BADGE #:  
DATE OF INJURY: 03/07/00  
DATE OF REPORT: 03/08/00  
SITE CODE: 140

S: The patient is no longer having excessive watering of his right eye. He still has some throat irritation.

O: ENT exam is normal.

A: 1. THROAT IRRITATION.  
2. HISTORY OF EXCESSIVE LACRIMATION, RIGHT EYE, RESOLVED.  
3. EMPLOYEE CONCERN REGARDING POSSIBLE BERYLLIUM EXPOSURE, OR OTHER TOXIC MATERIAL EXPOSURE, FROM DUST IN THIS INCIDENT.

P: Maintain the same restriction of no working in Building 9201-5E or low-humidity or dusty environments. Recheck is set for March 10, 2000. I have told him that we are awaiting an Industrial Hygiene evaluation of this situation.



STAN ROBERTS, PA-C

SR:cmh

Dictated but not edited

PATIENT NAME:  
SOCIAL SECURITY #:  
BADGE #:  
DATE OF INJURY: 03/07/00  
DATE OF REPORT: 03/10/00  
SITE CODE: 140

S: The patient is here for followup. He is asymptomatic.

O: Oropharynx appears normal.

A: SUBJECTIVE SYMPTOMS OF THROAT IRRITATION AND SUBJECTIVE SYMPTOMS OF EXCESSIVE WATERING OF HIS EYE, RESOLVED.

P: I called Tom Ford, Industrial Hygiene, and was advised that the Industrial Hygiene sampling did not reveal any over-exposure to beryllium. Emily Yowell is the industrial hygienist involved with this, and I will contact her for the full report. I removed his restrictions and discharged him from this injury. Safety and Industrial Hygiene are continuing to follow up on this incident. He will be allowed to go back into his work area when this has been cleared by Safety and Industrial Hygiene.

STAN ROBERTS, PA-C

SR:cmh

DICTATED BUT NOT EDITED

2000

WILLIS CORROON ADMIN. SERVICES

Name of Insurance Carrier

WILLIS CORROON ADMIN. SERVICES CORP.

Name/Address of Claims Handling Office

P. O. BOX 291587

City NASHVILLE State TN Zip 37229Phone # (615) 872-4000

## EMPLOYER

1. Name LOCKHEED MARTIN ENERGY SYSTEMSFederal Employer Identification # 52-13185162. Address P.O. BOX 2009City OAK RIDGEState TNZip Code 378313. Nature of business INDUSTRYPhone (423) 574-1582DO NOT WRITE  
IN THIS COLUMN

Carrier # (6)

## INJURED EMPLOYEE

4. Name

Social Security #

5. Address

City KNOXVILLEState TNZip Code 37918

County # (3)

6. Phone #

Occupation (job title) MachinistDepartment 50011357

Occupation (3)

7. Age 45 DOB 3/30/54Male ☒Female ☐Married ☐Single ☒

8. Number of hours worked: per day

: per week

: Number of days per week

9. Wages: per hour \$

: per day \$

per week \$

: Extra wages \$

Industry (4)

## DESCRIPTION OF THE INJURY OR OCCUPATIONAL DISEASE

10. Did the injury or exposure occur on the employer's premises? yes ☒ no ☐

If no, give the address of where it occurred

City

State

Zip

County

11. Describe what the employee was doing when the injury or exposure occurred: list tools, equipment or materials involved

Ownership (2)

were working in the hergulum area. My throat became very scratchy and burning. My sinuses feel like they are draining. My right eye has been

12. Describe fully how &amp; why the injury or exposure occurred

Watering. I had removed the filter from the wall unit air conditioner per

Nature (3)

13. Describe the injury or exposure in detail, giving the body part affected (examples: amputation of right index finger, fell down)

Injuring low back, exposed to chemicals causing breathing problemsthroat, eye

Body Parts (3)

14. Date of the Injury 3/7/00 : Hour of day 12:45 am ☐ pm ☒ Give the date of the notice or the injury or exposure to the employer, if different than the date it occurred15. Was the employee paid in full for the date of injury or exposure? Yes ☒ No ☐16. Has employee missed work because of the injury or exposure on any day after the date it occurred, including weekends or regularly scheduled days off? Yes ☐ No ☒ If yes, give date last worked 1/117. Has employee returned to work? Yes ☒ No ☐ If yes, give date 1/1  
Returning Wage: per hour \$ : per day \$ : per week \$

Type (3)

Source (4)

18. Did Employee die? Yes ☐ No ☒ If yes, give date 1/1 name/address of nearest relative19. Name/Address of physician P.O. BOX 2009 OAK RIDGE TN, 37831

Agency (4)

20. If hospitalized, name/address of hospital

Date report written 3/7/00Prepared by J. BakerTitle/Position DNC

I certify that the information given in this form is true, correct, and complete to the best of my knowledge.

Signature of injured employee

If employee is unable or refuses to sign, state

reason

Disability (1)

3/8/00 Report - T98<sup>3</sup> BIP-12880 Reference to Stone Island  
3/8/00 work list (for 3/7/00 visit) Skript  
3/8/00 work list (3/8/00 visit) Skript  
3/10/00 Report T975 BIP-12440 Reference to Stone Island  
3/10/00 work list Skript

RECEIVED MAR 24 2000

SITE Y-12		PAGE 2 OF 2	
EMPLOYEE NAME A		BADGE NO.	SOCIAL SECURITY NO.
OCCURRED (Date & Time) 3/7/00 12:45		REPORTED (Date & Time) 3/7/00 2:00	PLACE OF INJURY 9201-5E
SUBCONTRACTOR <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		BUILDING NUMBER 9201-5N	COMPANY SERVICE DATE 7/23/79
SHIFT		EMPLOYEE WORK PHONE 574-2821	SUPERVISOR Coke
REPORTED TO SUPERVISOR? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		OCCURRED ON OVERTIME? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	PAYROLL <input checked="" type="checkbox"/> HOURLY <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY
WAS INVOLVED PART EVER PREVIOUSLY AFFECTED BY INJURY OR DISEASE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		RADIOACTIVE OR TOXIC MATERIALS INVOLVED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If Yes, explain in Item 11.	SUPERVISOR'S PHONE NUMBER 574-2821
IF YES, EXPLAIN.		HOURS ON DUTY AT TIME OF INCIDENT 3.5	EXPERIENCE ON JOB/EQUIPMENT <input type="checkbox"/> 3 TO 12 MONTHS <input checked="" type="checkbox"/> MORE THAN 12 MONTHS
SAFETY EQUIPMENT WORN			
RESPIRATOR <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	GLOVES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	SAFETY GLASSES OR GOGGLES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	SEAT BELT <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
OTHER <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			SPECIFY OTHER.
FINDINGS BP 124/88 P 80 R 16 T 98.6 SpO2 = 97% working in 9201-5E inspection area - developed watering @ eye, throat irritation - worked in area 3 hrs in respirator. States he noted air filters were out of the three air conditioner units & was dust settled on equipment. He is concerned that there could be beryllium or other toxic material in the dust he was exposed to.			
TREATMENT PC (AO. NAD. ENT) except for bilateral cerumen removal. Eyes - penicillin. Erythromycin. Secretion. Erythromycin. O.D. Fluorescein exam OD + OS. Flit Comp exam for corneal abrasion on stippling. No FB seen. Resp: T. Cory. Irrigated eyes sterile eye wash solution. I called Tom Ford off & request of them exposure was done.			
X-RAYS TAKEN <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE INTERPRETATION.			
PRESCRIPTION MEDICATION <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DISPOSITION <input type="checkbox"/> FIT FOR WORK WITH NO RESTRICTIONS <input type="checkbox"/> SENT TO PHYSICIAN <input type="checkbox"/> SENT HOME <input checked="" type="checkbox"/> FIT FOR WORK WITH RESTRICTIONS (See UCN-16305 Restriction) <input type="checkbox"/> OTHER (Explain)			
TO RETURN <input checked="" type="checkbox"/> FOR PRECAUTIONARY CHECK <input type="checkbox"/> FOR ADDITIONAL TREATMENT <input type="checkbox"/> NOT NECESSARY			
DATE TO RETURN 3/8/00			
PRELIMINARY DIAGNOSIS & ICD9 ICD9 CODE DESCRIPTION ① Throat irritation ② Excessive lacrimation OD ③ Dust exposure - employee concerned re beryllium exposure			
NAME AND TELEPHONE NUMBER OF ANY WITNESSES			
FACSIMILE TO <input checked="" type="checkbox"/> WORKS <input type="checkbox"/> BENEFITS 3/7/00 DICTATION TO WORKS 3/8/00			
SIGNED (MD/PA/RN) Robert P. Bz			
DATE 3/7/00			
OTHER SIGNED (PSS)			
BADGE NO.			
DIVISION NO.			
DATE			